

INSIDE THIS ISSUE:

2010 List of Reportable Conditions	1
Rabies: Disease, PEP, & Reporting	2,
Why Report Communicable Diseases?	3
Interview: Marya Barker	4
CHESS New Users	5
By the Numbers	6

2010 List of Reportable Conditions

As authorized by South Carolina Statute #44-20-10 and Regulation #61-20, the S.C. Department of Health and Environmental Control (DHEC) updates the list of Reportable Conditions in January of each year. Revisions to the list of reportable conditions are based on many factors, including: 1) the need for DHEC to conduct surveillance on new conditions or to increase surveillance on certain existing conditions in order to protect the health of the public and 2) changes in reporting requirements from the U.S. Centers for Disease Control and Prevention (CDC).

The following revisions have been made to the 2009 List of Reportable Conditions:

New for 2010:

- Influenza hospitalizations (aggregate report of totals)
- Influenza laboratory confirmed cases by RT-PCR, DFA, and IFA
- Names of organisms have been added for some conditions
- Rabies post-exposure prophylaxis (recommended)

Revisions to the List of Reportable Conditions:

Rabies (human) has been moved to immediately reportable by phone.

CHESS entry:

Influenza hospitalizations (aggregate report of totals). **no change**

Influenza laboratory confirmed cases by RT-PCR, DFA, and IFA. **no change**

Rabies post-exposure prophylaxis (recommended). **change** See instructions on page 2.

Additional information and complete changes are available at:

Winter 2009 Epi Notes:

<http://www.dhec.sc.gov/health/disease/>

DHEC Web site:

<http://www.scdhec.gov/>

<http://www.scdhec.gov/health/>

<http://www.scdhec.gov/health/disease/index.htm>

Cards and posters are available from your regional DHEC Contact. (See attached list.)

2010 DHEC Disease Reporting Card (color is yellow for 2010)

2010 List of Reportable Conditions posters (color is yellow for 2010)

Remember!

1. Enter one disease per Morbidity Report, based on Condition and Specimen.
2. More than 1 lab test result may be entered if the specimen is the same.
3. Specimen Information refers to the specimen source (e.g. blood-venous, vaginal, NP).
4. Use special instructions available on the DHEC Internet site for CHESS Internal Users to report MRSA.
5. Use special instructions in this newsletter for reporting Rabies—PEP Recommended.
6. Call the Help Desk 1-800-917-2093 for password resets and immediate help.
7. Contact Ann W. Bell by email bellaw@dhec.sc.gov to request CHESS training, Report Function training,, or for more specific questions about CHESS use for data entry.

Rabies: Disease, PEP, & Reporting

Entering Rabies Post Exposure Prophylaxis (PEP) into CHES

Select Morbidity Report.

Enter patient data and demographics under Patient.

Under Morbidity Report tab, choose Condition as "Animal Bite – Species – PEP Recommended."

Enter Date of Morbidity Report. This is the date the information is entered into the system,

Enter Reporting Facility. This is the name of the hospital or provider's office.

Enter Treatment information: Treatment Date is the date PEP recommended. Treatment—choose Other. Custom treatment box will appear, then type "rabies PEP".

Press Add Treatment button.

Press Submit.

Rabies is an acute, progressive encephalomyelitis. The case to fatality rate is the highest of any infectious disease. The virus enters peripheral nerves, travels to the central nervous system, and replicates in the brain. The virus then travels distally to innervated organs, including the salivary glands where the virus is excreted in saliva. The rabies virus is most commonly transmitted by the bite of a rabid animal. Non-bite exposures can rarely cause rabies. Examples include a scratch from a rabid animal, if saliva could have been introduced into the wound, or contamination of a mucous membrane with the saliva of a rabid animal. Contacts with blood, urine, feces, etc. are not considered exposure. The incubation period for rabies is usually four to six weeks but the range is from as little as seven days to over six years. The time from exposure to onset

of illness depends on the severity, and thus the inoculum of virus into the wound, and the proximity of viral entry to the central nervous system.

Appropriate wound care combined with rabies PEP is almost universally effective in preventing infection.

Human rabies is uncommon in the United States. There are normally fewer than a half dozen cases per year, yet there are between 20,000 – 40,000 human exposures per year and approximately 7,000 – 10,000 animal rabies cases are diagnosed each year. Since dog rabies transmission has been virtually eliminated in the United States, the typical rabies hosts are raccoons, skunks, foxes and bats. In South Carolina there have been no cases of human rabies in over 50 years. Approximately 12,000 animal bites are reported each year in the state. About 200 animals test positive for rabies each year in our state; about 90% being are wild animals and 10 % domestic animals.

Since September 1, 2009, private providers are responsible for procuring rabies biologics directly from the manufacturers, distributors or pharmacies. The South Carolina Department of Health and Environmental Control will no longer provide rabies vaccine or human rabies immune globulin for postexposure prophylaxis (PEP). DHEC will continue to provide medical consultations to practitioners in determining if rabies prophylaxis is indicated for exposed individuals. As a reminder, the South Carolina Code of Laws Section 47-5-90 requires physicians to report animal bites. Animal bites should be reported to the DHEC county health department in the county where the exposure occurred within 24 hours of evaluation. Immediate notification of the health department allows DHEC to initiate the animal investigation. Since not all animal exposures require PEP, unnecessary PEP can often be avoided if the animal can be located for quarantine or testing. Through medical consultations, DHEC will assist providers in determining when PEP is indicated.

Article reprinted from Epi Notes Summer 2009: Dr. Linda Bell, DHEC

Why Report Communicable Diseases?

Health departments are charged with preventing the spread of communicable diseases in the community. Today, the majority of U.S. states and territories mandate reporting of common communicable diseases by health care facilities, physicians and laboratories. Surveillance of communicable diseases ensures timely implementation of disease control and prevention measures. Analysis of laboratory and morbidity reports supplies temporal and geographic patterns of disease, risk factors, and measures to evaluate prevention programs.

Timely reporting is vital for fast public health interventions such as investigation, identification of exposures, and implementation of control measures (such as recall of food products, isolation, quarantine, prophylaxis of contacts).

Examples of surveillance reports uses:

- Surveillance of communicable diseases allows rapid detection of the presence of an uncommon disease or microorganism e.g. detection of the H1N1 virus

- Reports of influenza-like illness, virologic influenza testing, rapid antigen tests, hospitalizations and deaths are very valuable in monitoring the circulation of the influenza virus and predicting the subtypes that will be partially responsible for the influenza activity in the coming season

- Reports of food-borne diseases and outbreak investigation produce the recall of numerous contaminated products and generate improvements in food-delivery systems

- Surveillance data shows that vaccine-preventable disease levels are at or near record lows.

However, there are still many under-immunized children, adolescents and adults. Reports of vaccine preventable diseases allow health departments to act promptly in stopping the spread of diseases by isolating cases and offering prophylaxis to contacts

Surveillance data can help identify clusters of illness such that public health prevention activities can be developed and implemented.

Surveillance data is also used in evaluating the effectiveness of such prevention activities

Surveillance allows the analysis of the most frequent pathogens

Surveillance data collected for antimicrobial susceptibility patterns and trends in resistance over time could help providers evaluate antimicrobial use

Surveillance data is used for allocation of funds for prevention activities and for identifying target groups

Reporting is required for healthcare facilities, physicians, and laboratories. Morbidity Reports by health care providers offer more information than Lab Reports (e.g. patient demographics, employment in sensitive occupation: child care, food handling, etc). This information is very valuable for prompt public health response.

Dana Giurgiutiu, PhD, MPH
Director of Division of Acute Disease
Epidemiology (DADE)

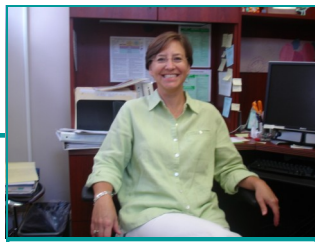


CHES Help Desk is closed on

February 15

2010 Epi Conference scheduled for

May 11 & 12



Marya Barker

Director of Surveillance for the Division of Acute Disease Epidemiology Marya Barker

You have a new position at DHEC? What are your responsibilities, especially related to CHES?

Marya: Yes, I do. As the director of the surveillance section, I'm generally responsible for making sure that we receive accurate and timely reports of disease occurrence in SC. More specifically, I document and report on vaccine-preventable diseases in SC as well as provide guidance to our regional folks on what data is needed in CHES and how to classify cases.

What experience in your past has helped you prepare for this position?

Marya: I've been a DHEC epidemiologist since 2003; first working in the local health department, then in the ER/ES in DADE and now in the Surveillance section. Having worked outbreaks firsthand in the region gave me a real appreciation for the challenges our epis face in gathering good surveillance data as well as the huge workload that providers contend with every day.

How does CHES entry assist your section? How is the information used?

Marya: CHES entry by external providers has been invaluable to us. The information is received by us in real time so we don't have to wait around on the cards to arrive before we act on the case. Also, when providers enter the data via CHES, the data is usually more detailed than the old cards. This can save a lot of time in telephone calls and records searching for everyone. We use the data to monitor trends in the community. The faster we receive the data, the faster we can initiate an investigation and take action to stop an outbreak.

What would you like to share about yourself outside of DHEC (hobbies, family, personal interests)?

Marya: My 11 year old daughter is a very enthusiastic junior epidemiologist. Having been taught by me that we should limit our contact with others when we're sick so we don't infect them, she is more than willing to stay home from school when she feels a little sniffle coming on.



Frequently Asked Questions

Question: How do I pull reports from CHES?

Help Desk: The Report Function is new to CHES External Users. Up to this time, only DHEC staff have been able to access the Report Function. To pull reports, the provider and user must first meet certain criteria. First, each user in a facility must sign a User Agreement. Second, each facility must sign a Memorandum of Agreement (MOA) with DHEC. Third, each facility must enter results in CHES for at least 30 days.

After meeting these 3 criteria, contact Ann W. Bell bellaw@dhec.sc.gov for a Reports training date. One or more users will be trained on how to pull reports for their facility. At this time, we have Morbidity Report Function available, and hopefully by the time you are ready, we will have Lab Report Function. You will only have access to your facility's information.

MOA and User Agreement forms are attached. When completed, please mail the original signed form to:
Ann W. Bell, MT-C, ASCP
CHES Coordinator;
1751 Calhoun Street
Columbia, SC 29201

Help Desk
1-800-917-2093

4 THINGS TO KNOW ABOUT YOUR CHES ACCOUNT

1. Remember to log into CHES at least once every 30 days to keep your account status active.
2. Never give others the right to use your password for any reason!
3. If you or someone in your facility leaves or will no longer need to use CHES, please let us know right a way. For security, we need to deactivate the account of anyone who is no longer using CHES.
4. Every user is given a temporary password at their initial training. Please remember to personalize your password within a week after training. Any passwords left unchanged will be deemed as inactive and deleted.

Welcome New CHES Providers and Users!

November: Ft Jackson Preventive Care, Rock Hill Family Practice,
Aiken Reg MC, Hilton Head Hospital

December: St. Francis Hospital and Eastside in Greenville, Beaufort Memorial

January: ARC in Charlotte, Catawba Care, Coastal Carolina Hospital, Hampton Reg MC,
CareSouth, Lifepoint, Inc.



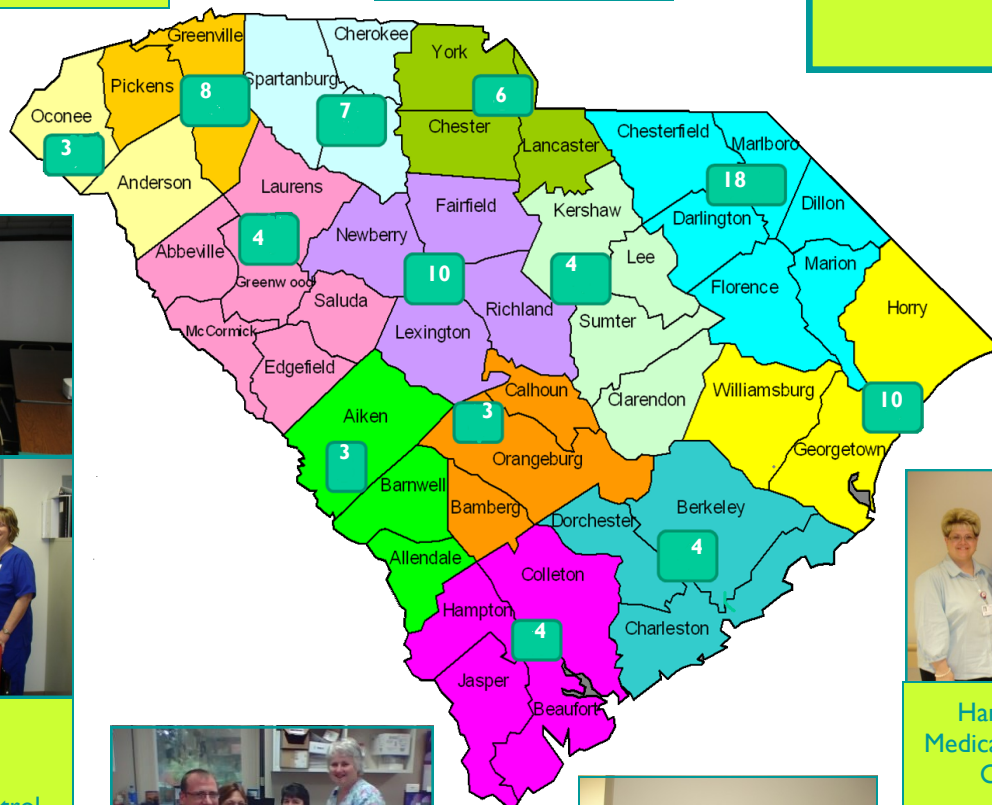
St. Francis Eastside-
Greenville



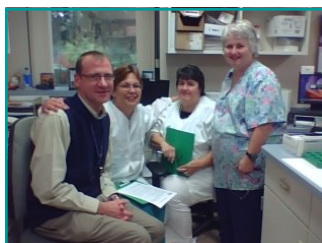
Fort Jackson
Preventive Medicine

CHES Providers
92

SC 87
Ga 3
NC 2



AnMed Health
Medical Center
Lab & Infection Control



Aiken Regional
Medical Center
Infection Control & Lab



Coastal Carolina
Hospital



Hampton Regional
Medical Center Infection
Control & Lab

2009 By the Numbers (as of Jan 2010)	Case Status		Total
	Confirmed	Probable	
Animal Bite - PEP Recommended	348	0	348
Aseptic meningitis	82	0	82
Brucellosis	3	0	3
Campylobacteriosis	266	3	269
Cryptosporidiosis	59	2	61
Cyclosporiasis	1	0	1
Dengue Fever	0	1	1
Ehrlichiosis, chaffeensis	0	2	2
Ehrlichiosis, ewingii	1	0	1
Giardiasis	104	0	104
Group A Streptococcus, invasive	79	0	79
Group B Streptococcus, invasive	48	0	48
Haemophilus influenzae, invasive	77	0	77
Hemolytic uremic synd, postdiarrheal	2	0	2
Hepatitis	2	0	2
Hepatitis A, acute	65	0	65
Hepatitis B virus infection, Chronic	122	494	616
Hepatitis B, acute	53	4	57
Hepatitis C Virus Infection, past or present	3,543	10	3,553
Hepatitis C, acute	1	1	2
Influenza, human isolates	380	0	380
Legionellosis	13	1	14
Listeriosis	13	0	13
Lyme disease	22	16	38
Malaria	7	0	7
Mumps	2	0	2
Neisseria meningitidis, invasive (Mening. disease)	10	1	11
Novel Influenza A Virus Infections (H1N1)	2,039	24	2,063
Pertussis	223	22	245
Pesticide Poisoning	1	0	1
Psittacosis (Ornithosis)	0	1	1
Q fever	1	1	2
Rocky Mountain spotted fever	3	17	20
Salmonellosis	1,191	8	1,199
Shiga toxin-producing Escherichia coli (STEC)	21	2	23
Shigellosis	125	2	127
Strep pneumoniae, invasive	489	0	489
Tuberculosis	147	0	147
Varicella (Chickenpox)	114	14	128
Vibrio parahaemolyticus	9	1	10
Vibrio spp., non-toxigenic, other or unspecified	2	0	2
Vibrio vulnificus infection	2	0	2
West Nile Fever	1	2	3
Yersiniosis	8	0	8